



Nancy Wyman
LIEUTENANT GOVERNOR
STATE OF CONNECTICUT

Healthcare Cabinet Meeting Minutes

July 12, 2016

Members in Attendance: Lt. Governor Nancy Wyman, Ellen Andrews, Patricia Baker, Benjamin Barnes (OPM), Kurt Barwis, Roderick Bremby (DSS), Tim Curry (CID), Miriam Delphin-Ritmon (DMHAS), Margherita Giuliano, Bonita Grubbs, William Handelman Michael Michaud (DMHAS) Frances Padilla, Raul Pino (DPH), Jordan Scheff (DDS), Kristina Stevens (DCF), Shelly Sweatt, Bob Tessier, Jim Wadleigh (Access Health CT) ;

Members Absent: Susan Adams, Demian Fontanella (OHA), Gary Letts, John Oraziatti, Josh Wojcik (OSC) Hussam Saada, Lawrence Santilli, Gregory Stanton

Others present: Victoria Veltri (Lt. Governor Office); Kate McEvoy (DSS); Anne Foley (OPM); Michael Bailit, Megan Burns and Marge Houy, Bailit Health Purchasing, LLC

Agenda Item	Topic	Discussion	Action
1.	Call to order & Introductions	Lt. Governor called the meeting to order.	
2.	Public Comment	No public comment	
3.	Review & Approval of minutes	Meeting minutes reviewed June 14, 2016	Minutes approved: Pat Baker motions and Bob Tessier seconded
4.	Presentation of Bailit Health's Straw Proposal	<u>Setting the Context.</u> Marge Houy, Senior Consultant, reviewed the legislative charge to develop a cost containment strategy with the Cabinet. She also reminded the members that there was a need for action to reduce the cost of care and improve quality,	

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		<p>based on Connecticut’s current health care system performance. She also noted that the state budget crisis provided a “burning platform” to motivate action.</p> <p><u>Straw Proposal.</u> Megan Burns, Senior Consultant, outlined a six-point straw proposal to contain costs and improve quality. The key components are as follows:</p> <ol style="list-style-type: none"> 1. Improve population health by creating Consumer Care Organizations (CCOs), which are consumer-driven, advanced provider networks responsible for improving the health of an attributed population. CCOs would be for Connecticut residents with either public or commercial coverage. 2. Limit cost growth by setting requirements and limitations on the increase in health care costs, set targets for adoption of alternative payment model adoption through Medicaid and the Office of Comptroller contracting activities, and CID regulatory activities, and create a new governmental structure (Office of Health Reform) to establish and monitor target achievement. 3. Support providers to transform by pursuing a Section 1115 Medicaid Waiver and request a 5-year Delivery System Reform Incentive Payment (DSRIP) program to access new federal funds for provider infrastructure investment. 4. Support market competition by giving the Attorney General additional subpoena powers to collect confidential information from plans and providers to examine and report on trends in costs to improve transparency and promote competition 5. Use data to make public decisions by promoting the development of a robust All Payer Claims Database and Health Information Exchange, and by incorporating the use of comparative effectiveness evidence to reduce overuse and misuse of health care services. 	

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		<p>6. Coordinate and align state strategies by restructuring existing agencies into a single state entity composed of all health-related state agencies. This agency would be responsible for aligning all state health policy and purchasing activities.</p> <p>The PowerPoint presentation which outlines the straw proposal in more detail is available on the Connecticut Office of Health Advocate website: http://portal.ct.gov/hcc/</p>	
5.	Clarifying Questions	<p>Megan provided the following additional information in response to clarifying questions asked by Cabinet members:</p> <ol style="list-style-type: none"> 1. The CCO would be for both publicly funded and commercially funded health care services, and not limited to Medicaid; however contracting would be separate. 2. The CCOs as presented address medical/dental/behavioral health needs, but could be expanded to address social determinants of health, such as housing and transportation. 3. A quasi-independent agency could sit either inside or outside of the Executive Branch. Massachusetts Health Policy Commission and Vermont's Green Mountain Care Board are examples of quasi-independent agencies. In both cases some members are appointed by the Governor or other officials. In Massachusetts the legislature also appoints some members. The important point is that the members do not serve at the direction of the Governor. 4. The agency restructuring could be done in a number of ways. It could encompass a broader scope of services and function like a secretariat, as in Massachusetts, or it could be health focused, as in Oregon. 5. In the Bailit proposal for creating an integrated agency, DDS was omitted by mistake. 6. When asked how the Office of Health Reform would be funded, Megan indicated that that would need to be 	<ul style="list-style-type: none"> • None

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		<p>determined. Massachusetts' Health Policy Commission is funded through provider taxes.</p> <p>The Office of Health Reform would be responsible for setting cost containment targets and the Connecticut Health Authority would be responsible for developing and implementing cost containment initiatives to meet the target.</p>	
6.	Discussion	<p>DRAFT</p> <ul style="list-style-type: none"> • Commissioner Pino noted that the CCO proposal does not directly address social determinants of health. Megan Burns noted that measures and contract requirements for CCOs could address social determinants of health. • Dr. Handelman stated the opinion that the state has not created an effective HIE, which is essential to implement this Straw Proposal. He also thought the timing was “terrible” given the impact MACRA would have on physicians with most physicians not prepared for MACRA. Megan explained that MACRA was a CMS program that links provider payments to quality improvement and promotes use of alternative payment models. She thought that the Straw Proposal does not conflict with MACRA and may, in fact, help providers meet MACRA requirements. • Bob Tessier expressed strong support for the Straw Proposal, but noted that it does not address pharmacy costs. • Margherita Giuliano suggested that pharmacy costs could be addressed in part through enhanced AG powers. Marge Houy noted that a number of states are considering, and Vermont has enacted, drug price transparency statutes that give the AG powers to request cost data from drug manufacturers and impose fines if the data are not provided. She noted that the Vermont legislation then requires the AG to submit a report to the legislature and the Medicaid agency, but is prohibited from disclosing any information that reveals the manufacturer’s name. 	Bailit Health will consolidate feedback and develop an approach for the next meeting that promotes further discussion of cost containment and quality improvement strategies.

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		<ul style="list-style-type: none"> • Bonita Grubbs said that she likes starting on the consumer side and making them central, further noting that there is a need to educate and help prepare consumers. Marge Houy suggested that the Straw Proposal could include provisions for training consumers to be board members and a consumer advisory board could be added to the Connecticut Health Authority, as is the case with the Oregon Health Authority. • Anne Foley expressed the concern that agency consolidation would result in no efficiencies and the loss of consumers' voices and access. She also indicated that there were no state funds to pay upfront costs to implement these recommendations. She expressed interest in the idea of pushing risk down to providers, but worried about withholding rate increases for non-CCO participants because it might imply future increases, which cannot be guaranteed. Anne suggested that instead of a major agency reorganization better coordination could be achieved through steering committees and as a result of the Lt. Governor's Office's new function. • Kristina Stevens asked how the proposal could be implemented without losing the gains currently achieved by the State. Marge noted that the major delivery system reform is around Patient-Centered Medical Homes, which include providers who control approximately 10 to 12% of health care spending and can only achieve so much. Megan Burns added that the proposal builds on what is currently happening in the state and does not detract from it. • Jim Wadleigh provided an example of the cross-agency group that is meeting bi-weekly to discuss shared services as an alternative approach to the proposal to consolidate agencies. He noted that this group is finding cost savings opportunities. 	

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		<ul style="list-style-type: none"> • Pat Baker expressed support for the proposal and asked for more detail on how the state could bring in the commercial side to align strategies with Medicaid. Michael Bailit, President of Bailit Health, noted that Rhode Island’s Office of the Health Insurance Commissioner has established alternative payment model standards and a core data set which both it and Medicaid will be implementing. Pat stated that she thinks that a unified planning structure is essential to assure implementation of reform. • Commissioner Bremby stated that he thought a great deal could be accomplished without agency restructuring, noting that restructuring requires enormous effort based on his experience in a Midwestern state. He noted that the Connecticut Medicaid program has a cost structure less than the national average with a decrease in PMPM costs since 2012. Connecticut is a model Medicaid program nationally. He indicated that his team would vet the proposal and return at a future meeting ready to engage. • Commissioner Delphon-Rittmon requested more information about states that have pursued agency consolidation and then moved back. Michael noted that the states that are successful, such as Oregon, have provided strong leadership to bring the agencies together. He agreed that restructuring alone would not improve communications. • Frances Padilla asked if Medicaid and commercial advanced networks have the same cost cap. Megan Burns clarified that the Straw Proposal is for a limit on cost increases, not rate setting. • Kurt Barwis asked if the Proposal would allow an advanced network to take full risk. Megan Burns stated that full risk could be an option. 	

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		<ul style="list-style-type: none"> • Dep. Commissioner Tim Curry asked about who would manage the growth cap, specifically who would decide the cap levels for different segments of the payer community. Michael Bailit explained that there it could be done at the state level through coordinated agency action. He noted in Vermont, which is setting up a single, state-wide ACO, the decisions are being made within the ACO. • Ellen Andrews expressed the following views: <ul style="list-style-type: none"> ○ She is concerned that consumers would have fewer places to be heard under a consolidated agency ○ Without trust, how can this model be implemented. She suggested taking baby steps, noting that the distrust among the stakeholders has been earned. ○ She is uncomfortable with having one focus for making health care policy. She likes the different voices and the state should find ways to develop a consensus. ○ She does not like HUSKY and state employees being combined. Megan Burns clarified that the Straw Proposal does not propose that they be combined, but to have some common contracting provisions. ○ She does not like capitation. Megan Burns clarified that the Straw Proposal recommends shared risk, not capitation. Ellen does not support shared risk. ○ She does not see PMCH+ (MQISSP) as a strong foundation upon which to build because it is so new. ○ She said that 1115 Waivers do not fit with Connecticut values. ○ She likes comparative effectiveness programs. 	

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		<ul style="list-style-type: none"> ○ She thinks giving the AG subpoena power is not enough to counter consolidation. ○ She does not like caps because they do not work and providers have too much power. ○ Ellen noted that she needs more time to provide her input. ● Commissioner Pino made the following points: <ul style="list-style-type: none"> ● We need an emphasis on prevention. ● We need educated consumers who are informed and rewarded. ● We need transparency in pricing. ● We need a health information exchange to prevent duplication of services. ● He disagrees with consolidating all of the agencies. There is an urban myth that we do not work together. ● We need an implementation timeline. ● Kurt Barwis liked the agency consolidation to create common goals and accountability. He thinks that the way to start to address the trust issue is to come to consensus on a common model and not keep changing it “every five minutes.” It is problematic when things are constantly changing. ● Kurt Barwis suggested that there may be a role for CCOs to connect to local agencies responsible for housing, jobs, etc. He sees a need for there to be a stable governance structure at the community level to coordinate services and set local priorities. He wants to see the role of the CCOs enriched to provide more of a community integration role. ● Bob Tessier asked about next steps to integrate comments and continue the discussion. Marge Houy explained that discussion will continue over the next two meetings and that Bailit Health will have some internal 	

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		<p>communications to decide how to best structure the discussion.</p> <ul style="list-style-type: none"> • Bonita Grubbs noted that we all should be aware that people may be speaking from their own self-interest. <p>Kate McEvoy noted that Medicaid is doing a great deal currently to control costs and asked that that work be acknowledged.</p>	
7.	Next Steps	Next meeting will be held on September 13, 2016 at the LOB, Room 1D, 9:00 AM – 12:00 PM	
8.	Adjourn		Adjourned: Pat Baker motioned and Anne Foley seconded

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